ARCHDIOCESE OF PORTLAND
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LIFE EVENT CHANGE WORKSHEET 2017 – 2018

Before completing this worksheet, be sure that you have read and understand the details of your Health Benefit Plans and the list of qualifying events. These documents are effective July 1, 2017, and are available on the Benefits Office page of the Archdiocese website. Download at https://archdpdx.org/benefits-administration-1 . Ask your employer to print a copy for you if you do not have online access.

Important Things to Know

You may not change your benefit selections outside of an open enrollment period unless you have an event that qualifies as a change in status under IRS regulations and our contracts with insurance carriers.

The following forms must be completed and submitted along with any relevant documentation to your Payroll/Benefits Administrator within 30 calendar days (60 days for Medicaid/state plan) of the event date. When terminating coverage, you may have to forfeit premiums if you do not report the status change before the event date.

If you are adding dependents to your Health Benefits, you must validate with approved documents. After submitting documentation, your dependents will remain in pending status until all documentation is validated. See page 4 for the list of approved validation documents.

Remember, you can waive medical only if you have other medical coverage.

You must select a Dental/Vision plan.

All coverage begins on the 1st day of the month following the event, unless the event date is the 1st of the month, in which case coverage begins immediately on the 1st.

Status Change Guidelines

Please note:

- All changes are subject to approval.
- If there is a unique situation, contact BAS for further direction.
- If you are on an unpaid FMLA or other leave of absence, special rules apply to making changes before, during, and upon return from your leave in addition to the options listed in the chart for FMLA. Contact your employer for details.

Tax Consequences of Retroactive Changes

To avoid tax consequences when the following changes are made retroactively (after the event date), you must sign and submit a new enrollment form by these deadlines:

- If enrolling in an Archdiocesan health plan due to loss of other coverage, the change must be submitted on or before coverage ends
- If you get married, on or before your marriage date
- If terminating participation in an Archdiocesan health plan because of eligibility for another employer-sponsored plan, Medicare, or Medicaid, before the other plan becomes effective

If you submit an enrollment form after the above deadlines, but within 30 days (except for Medicaid or CHIP coverage, which allows 60 days) of the event, your payroll adjustments will be affected in these ways:

- If you already have a before-tax deduction, a change in coverage will not change the before-tax deduction amount.
- Any additional premium cost will be deducted after taxes.
- If you waive your own medical coverage or stop coverage for family members who are still eligible, the premium and coverage change will become effective the first of the month after the form is signed and submitted (this could result in a brief period of double coverage).

This treatment of before and after-tax earnings will continue until the next plan year unless another status change occurs and you submit a new form by the deadlines listed above.

IMPORTANT: Be sure to turn in the following forms along with any required dependent validation documents to your Payroll/Benefits Administrator **within 30 calendar days of the qualifying life event**.

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(Administrative Use Only)

Location Name: _____

BAS Location #: _____

Qualifying Event: _____

Approved: Yes No

Approval Date: _____

Effective Date of Coverage Change: _____

EMPLOYEE LIFE EVENT CHANGE REQUEST

Employee Information

Name: _____ Employee ID: _____

SSN: _____ Date of Hire: _____

Date of birth: _____ Salary: _____

Spouse Information

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____

Dependent Information

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____ Relationship: _____

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____ Relationship: _____

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____ Relationship: _____

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____ Relationship: _____

Name: _____ Date of Birth: _____ Add* ☐ Drop ☐

SSN: _____ Relationship: _____

***IMPORTANT**: Be sure to turn in this form along with any required dependent validation documents and the Status Change Declaration to your Payroll/Benefits Administrator **within 30 calendar days of the qualifying life event**.

STATUS CHANGE DECLARATION

(Mark all that apply.)

The change in status marked below affects:

- ☐ Self
- ☐ Spouse
- ☐ Children

Change in Marital Status:

- ☐ New marriage
- ☐ Death of spouse
- ☐ Annulment
- ☐ Divorce

New Dependent:

- ☐ Biological child
- ☐ Child adopted / placed for adoption
- ☐ Legal Guardianship
- ☐ Stepchild

Lost other coverage or obtained new coverage due to:

- ☐ My other employment
- ☐ Loss of Medicare, Medicaid, or other state plan
- ☐ Other employer's open enrollment
- ☐ Eligible for Medicare or Medicaid
- ☐ Spouse's or parent's employment
- ☐ Loss of Indian tribal government coverage
- ☐ Child's employment
- ☐ Exhaustion of COBRA
- ☐ Exhaustion of state continuation
- ☐ Loss of foreign government plan

Change in status of dependent child:

- ☐ Child's marriage
- ☐ Child's death
- ☐ Court order for another person to provide coverage
- ☐ Court order for myself to provide coverage
- ☐ Child no longer meets eligibility requirements in current DMG

Coverage area:

- ☐ Other group plan newly available in my area
- ☐ Group plan no longer available in my area

Other:

- ☐ Significant change in Archdiocesan program premium cost or coverage during the Archdiocesan plan year
- ☐ Family Medical Leave Act

HEALTH BENEFITS COST PER EMPLOYEE 2017-2018

Use this sheet to complete your benefits selections. Circle a Medical and Dental/Vision selection below.
Rates are net.

Basic Monthly Benefit Rate for Employees per month

Medical Plans – required unless you have other current medical coverage

	Employee Only	Employee + spouse	Employee + children	Employee + family
WAIVE MEDICAL	No cost			
Kaiser DEPO 500-1-st-CO *NEW*	No cost	$209.00	$116.00	$320.00
Kaiser EPO	$27.00	$299.00	$190.00	$443.00
UHC PPO 750-2 *NEW*	No cost	$274.00	$171.00	$418.00
UHC PPO 500-2 *current*	$31.00	$327.00	$214.00	$490.00
UHC PPO 500-1 (replace UHC 250) *NEW*	$68.00	$339.00	$234.00	$523.00

Dental/Vision - Required

Reta Delta Dental	No cost	$40.00	$22.00	$58.00
Willamette Dental	-$25.00	$2.00	-$10.00	$20.00
Kaiser Permanente Dental	-$6.00	$37.00	$20.00	$55.00
Vision – RETA VSP	Included	Included	Included	Included

Healthcare Flexible Spending Account "FSA" - *Optional*

If you elect this coverage, a pro rata portion of your annual election will be deducted from each of 12 remaining pay periods in the plan year 2017

Maximum election is $2,600.00 per year. Write in the amount of your monthly election.	

Pre-tax costs – Medical, Dental/Vision, and Healthcare FSA

Add medical, dental/vision, and FSA and enter total here	

Dependent Care Reimbursement Plan – "DCRP" - *Optional*

If you elect this coverage, a pro rata portion of your annual election will be deducted from each of 12 remaining pay periods in the plan year 2017

Maximum election is $5,000.00 per year. Write in the amount of your monthly election	

Optional Post-tax benefits

Additional Life/AD&D - *Optional*

To enroll family members, you must select coverage for yourself. See rate sheet for premiums and the schedule of age-based premium increases.

Employee coverage amount $_____ (cannot exceed lesser of $500,000 or 5x annual wages. Do not include your basic Life/AD&D amount here). After tax – enter cost here	
Spouse coverage amount $_____ (cannot exceed 100% of employee coverage). After tax – enter cost here	

Child(ren) coverage amount (cannot exceed 100% of employee coverage)	$1.80 ($6,000)	$2.40 ($8,000)	$3.00 ($10,000)	After tax – enter cost here	

Short-Term Disability - *Optional*

OPT OUT No cost	$3.28 44-day elimination	$5.64 30-day elimination	$7.98 14-day elimination	After tax – enter cost here	

Buy-up Long-Term Disability - *Optional*

$6.62 LTD - 60% of wages	$9.75 LTD – 66 2/3% of wages	After tax – enter cost here	

Total Post-tax costs

Add amounts in shaded boxes above and enter here	

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RETA TRUST APPROVED DEPENDENT VALIDATION DOCUMENTS

Dependent Type	Approved Documents Requirement
Spouse	Marriage certificate **plus** one piece of documentation dated within the past 60 days to establish a common residence or financial interdependence – Examples of secondary documentation: • Jointly filed Form 1040 • Separately filed Form 1040 with the same address • Financial documents in both parties name • Utility bill in both parties name
Child to age 26	Birth certificate listing the employee's name Hospital Birth Record (newborns only)
Stepchild	Birth certificate naming spouse as the child's biological parent **and** Marriage Certificate **and** Jointly filed 1040* Separately filed 1040 with same address* Financial document in both names Utility bill in both names
Disabled Dependent	Birth certificate **and** a copy of the employee's recent Form 1040 claiming the individual as a dependent OR the dependent's Form 1040 filed from the employee's address OR SSDI documentation
Adoption/placed for adoption	Appropriate court document
Legal Guardianship/Foster Child	Court document establishing employee or the employee's spouse is the legal guardian

* Not required of marriage less than 90 days

IMPORTANT: To expedite the status change process, be sure to submit any required dependent validation documents along with your election change worksheets. All forms and documents must be turned in to your Payroll/Benefits Administrator **within 30 calendar days of the qualifying life event**.

LIFE EVENT STATUS CHANGE CHART

Event	Medical/Prescription Drug & Dental/Vision	Healthcare FSA	Additional Life/AD&D STD & Buy-up LTD
Marriage	**Add** self/family members if adding new spouse or new dependents **Drop** self or dependents whose coverage starts under new spouse's employer **Switch** medical plans if adding new family members	**Add or increase contributions** **Drop or decrease contributions** if family members become covered under a spouse's employer's health care or HCSA plan	Add, increase, decrease, or drop
New dependent (birth, adoption, placement for adoption)	**Add** self/family members if adding new dependent **Drop** family members whose coverage starts under spouse's employer **Switch** medical plans if adding new dependent	**Add or increase contributions**	Add, increase, decrease, or drop
Divorce, annulment	**Add** self/dependents whose coverage ends under former spouse's employer **Must Drop** former spouse **Drop** family members whose coverage starts under former spouse's employer **Switch** medical plans if adding self/dependents	**Add or increase contributions** if health coverage or HCSA is lost under former spouse's employer **Drop or decrease contributions**	Add, increase, decrease, or drop
Spouse dies	**Add** self/dependents whose coverage ends under former spouse's employer **Must drop** deceased spouse **Switch** medical plans if adding self/dependents who lost coverage under former spouse's employer	**Add or increase contributions** if health coverage or HCSA is lost under deceased spouse's employer **Drop or decrease contributions**	Add, increase, decrease, or drop
Child dies or loses eligibility	**Must drop** child	**Drop or decrease contributions**	Decrease or drop
You, your spouse, or child becomes covered under other employer plan	**Drop** self/family members who become covered under other employer (employee cannot waive own dental/vision coverage)	**Drop or decrease contributions** if health coverage or HCSA starts under other employer	Decrease or drop
You, your spouse, or child has change in employment status resulting in loss of other employer plan, or you lose coverage under a parent's employer plan	**Add** self/family members losing coverage under other employer **Switch** medical plans if adding family members	**Add or increase contributions** if health coverage or HCSA is lost under other employer	Add, increase, decrease, or drop
Election to terminate coverage under another employer plan during other employer's open enrollment or special election period	**Add** self/family members losing coverage **Switch** medical plans if adding family members	None	None

Event	Medical/Prescription Drug & Dental/Vision	HCSA	Additional Life/AD&D STD & Buy-up LTD
Medicare, Medicaid, or CHIP coverage change	**Add** family members losing coverage **Switch** medical plans if adding family members **Drop** family members who become covered under Medicare Part A, B, or D or Medicaid	**Add or increase contributions** if family members lose eligibility **Drop or decrease contributions** if family members become covered	None
Any family member moves into or out of health plan's coverage area	**Add** family members losing coverage under other plan who have no other benefit option **Switch** plans if adding family members **Drop** family members outside of area **Waive** own coverage if eligible for another employer plan	None	None
Court order to add coverage	**Add** children covered by order **Drop** if court orders coverage by another person	**Add or increase contributions** if required to provide health coverage **Drop or decrease contributions** if other person required to provide health coverage	None
Significant change to Archdiocesan program such as premium increase or dropping or adding plans during the plan year	**Drop** family members **Switch** plans **Waive** own coverage if enrolling in another plan	None	Drop or decrease
Loss of medical coverage due to exhaustion of COBRA or state continuation period	**Add** family members losing coverage **Switch** medical plans if adding family members	**Add or increase contributions**	None
Wage increase or decrease	None	None	**Must reduce** life/AD&D coverage if wage-based maximum would otherwise be exceeded
Any family member loses coverage under state health benefits pool, Indian tribal government coverage, or foreign government plan	**Add** family members losing coverage **Switch** medical plans if adding family members	None	None
Unpaid leave protected by Family Medical Leave Act	**Stop** contributions **Prepay** coverage during leave	**Stop** contributions **Prepay** coverage during leave	Increase or decrease